PRINTED: 08/24/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 09G141 08/05/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW **METRO HOMES** WASHINGTON, DC 20012 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PLETION PRÉFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) W 000 INITIAL COMMENTS W 000 A recertification survey was conducted from August 3, 2011 through August 5, 2011. A sample of three clients was selected from a population of six women with profound intellectual and developmental disabilities. This survey was Health Regulation & Licensing Administration initiated utilizing the fundamental survey process. Intermediate Care Facilities Division 899 North Capitol St., N.E. The findings of the survey were based on observations and interviews with staff and clients Washington, D.C. 20002 in the home and at one day program, as well as a review of client and administrative records. including incident reports. W 159 483.430(a) QUALIFIED MENTAL W 159 RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: W159 Based on observation, interview and record 8/29/11 1. The staff involved has been review, the facility's qualified mental retardation disciplined and re trained in this professional (QMRP) failed to coordinate. integrate and monitor services, for one of the individual's mealtime protocol. three clients in the sample. (Client #1)

The findings include:

1. [Cross-refer to W194.1] The QMRP failed to ensure that all staff assigned to assist Client #1 with her meals in the home received effective training, to ensure implementation of the client's Mealtime Protocol, as written.

2. [Cross-refer to W194.2. and W249] The QMRP failed to ensure that staff in the home and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

1. The staff involved has been disciplined and re trained in this individual's mealtime protocol. The QDDP and the RC/RN will ensure that they monitor the staff during mealtimes at least 2x/week, to ensure that the mealtime protocol is being followed.

TITI F

(X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14

days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		H AND HUMAN SERVICES E & MEDICAID SERVICES				FORM): 08/24/201 A APPROVED): 0938-039
MEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE S	SURVEY
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NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		05/2011
METRO	HOMES	·		143	33 NORTHGATE ROAD, MW ASHINGTON, DC 20012		
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W 159		~	W 15	59			
	training to ensure in	d to ensure effective the facility's adaptive	:	1	The QDDP has scheduled the communication device training this individual's day program. The Speech/Language pathol will ensure that staff are training.	ng for n staff. logist ned	1 · · · · · · · · · · · · · · · · · · ·
	recommended by Ci (PT) and primary ca	led seating system was client #1's physical therapist are physician in October 2010. 1, the client was without the] 1 (and are able to implement the program. The QDDP will ense that she and the Activities Coordinator monitor the staff least weekly to ensure the pro-	sure f at ogram	*
	approximately 9:40 a that she had sought wheelchair vendors. #1's PT records faile to secure the custom October 15, 2010. b. On August 5, 2011 Client #1's Individual December 14, 2010, that her wheelchair verference to the Sear Assessment, dated 0 the PT wrote that the disrepair," provided "insufficient pressure	October 15, 2010, in which e seating system "was in "insufficient support" and e relief" and was		II a a a a a a a a a a a a a a a a a a	is being implemented correct. The paperwork to request a number wheelchair has been sent to the Vendor and will be forwarded. Delmarva for approval. The Cand Metro Homes will work closely with the DDS adaptive equipment rep. to ensure that WC is obtained expeditiously. There will be current documentation and weekly up to DDS regarding the progres obtaining this WC.	he d to QDDP Te a new Todates as of	
	"uncomfortable" for the	he client.	Æ	All s	staff were in serviced on the d	laily	

c. On August 5, 2011, at 10:10 a.m., review of

the QMRP wrote Client #1's "seating system is

QMRP quarterly summary reports revealed that on March 18, 2011, and again on June 17, 2011,

All staff were in serviced on the daily adaptive equipment monitoring form.

See attached in service record and WC

- paperwork sent to vendor.

*MENT OF HEALTH AND HUMAN SERVICES **FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE: COMPI	SURVEY LETED
·		09G141	B. WING		08/	05/2011
	PROVIDER OR SUPPLIER HÖMES		14	EET ADDRESS, CITY, STATE, ZIP C 33 NORTHGATE ROAD, NW ASHINGTON, DC 20012		
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W 159	Continued From pa	age 2	W 159			
	report made refere Assessment, dated included the aforei	er needs at this time." Neither need to the Seating and Mobility d October 15, 2010, that mentioned problems and the or a new custom molded.	:			
	seating system.	or a new custom monded	i	,		
	stated that direct sequipment checklis of the condition of 12:04 p.m., review program book reve August 5, 2011, direported that no reseating system, or 2011, however, the wheelchair was observed.	11, at 11:56 a.m., the QMRP upport staff used an adaptive st to document daily monitoring clients' adaptive equipment. At of the checklist in Client #1's saled that from October 2010 - ect support staff routinely pairs were needed for her the arm rest. On August 3, right arm rest of her served to be damaged. There sat the QMRP had verified the ff documentation.				
	e. Review of the far Policies and Proce approximately 2:15 QMRP has the prin facilitating the timel replacement of equi modification or replacement shall oc from when the need (replacement) do the QMRP shall pro-	cility's Adaptive Equipment dures on August 5, 2011, at p.m. revealed that "The nary responsibility for y repair, modification, or ipment Acquisition, repair, accement of adaptive cur within 60 days of the date of was determined If se not occur within 60 days, wide written notice to" the responsible for placements				
	and monitoring of c later, interview with had not notified the include "reasons for	lients in the home. Moments the QMRP confirmed that she DDS Service Coordinator, to the delay and strategies to as per the agency's policies				

MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
i		09G141	B. WING)	OR/C	5/2011
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
W 159	revise Client #2's to the client's poor ora 5. [Cross-refer to Wensure at least one certification year to of its residents.	/257] The QMRP failed to poth brushing program despite all health. /445] The QMRP failed to full evacuation during the past ensure the health and safety	W 15	4. The individual's tooth program has been ame ensure that her oral hymmaintained. All staff hatrained in the new program 5&6 All staff were trained Inspector Madison on Fire Evacuation. There is a writh Procedure for the evacuation.	nded to giene is ave been gram. by Safety and tten on of the	
	who required wheel to exit the facility sa emergency evacual residing in the facilit 483.430(e)(4) STAF Staff must be able to techniques necessariant.	ovisions to ensure all clients chairs for mobility were able fely in the event of antion for three of six residents by. FF TRAINING PROGRAM or demonstrate the skills and ary to implement the individual ach client for whom they are	W 19	WC individuals if the ram inaccessible. In the future the QDDP an will ensure that all staff armonitored and are capable implementing all programs health and safety of the income.	d RC/RN e trained and of s for the	i
	Based on observativerification, the facil demonstrated comp clients' individual prothree clients in the s. The findings include 1. The facility failed	to ensure that staff etency in implementing Client	: : :	W 194 1. The staff involved has been disciplined and re trained in the individual's mealtime protocologous and the RC/RN will enthey monitor the staff during mealtimes at least 2x/week, to that the mealtime protocol is	this ol. The insure that o ensure	8/29/11

followed.

*MENT OF HEALTH AND HUMAN SERVICES > FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2011 FORM APPROVED OMB NO. 0938-0391

AT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

09G141

B. WING

08/05/2011

NAME OF PROVIDER OR SUPPLIER

METRO HOMES

STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

W 194 Continued From page 4

a. Client #1, who was dependent on staff to feed her due to severe contractures of both hands, was observed being fed breakfast in her home on August 3, 2011, beginning at 8:25 a.m. The meal consisted of an English muffin, hard boiled egg and cold cereal, all prepared at a pureed consistency. The direct support staff (S2) feeding her alternated between the food and cranberry-apple juice drink throughout the meal.

Client #1 was observed at her day program on August 3, 2011. Beginning at 12:24 p.m., staff fed her lunch which consisted of pureed meat, peas, mashed potatoes and apple sauce. Unlike breakfast observations, day program staff did not offer the client any fluids while she ate. At 1:03 p.m., the day program staff said she would give the client water and a Boost Plus nutritional supplement 30 minutes after she finished her lunch, as per the client's Mealtime Protocol (MP). Review of the MP, dated December 5, 2010, revealed the following instruction: "30 minutes after breakfast: 1 c milk" and "30 minutes after lunch: 1 c fluid."

b. On August 5, 2011, at 7:41 a.m., S2 was observed feeding Client #1 her breakfast. At 7:54 a.m., after the client had finished eating her food, S2 gave the client Boost Plus nutritional supplement, using a nosey cup. Review of the same MP, dated December 5, 2010, revealed that the Boost Plus was to be given as a "mid-morning snack," not with her breakfast:

On both mornings, S2 failed to implement Client #1's MP, as written.

Staff in-service training records were reviewed in

W 194

2. The QDDP has scheduled the communication device training for this individual's residential and day program staff. The Speech/Language pathologist will ensure that staff are trained and are able to implement the communication program effectively. The QDDP will ensure that she and the Activities Coordinator at the day program monitor the staff at least weekly to ensure the program is being implemented correctly.

In the future the QDDP and RC/RN will ensure that all staff are trained and monitored and are capable of implementing all programs for the health, rehabilitation and safety of the individuals.

CENTER	<u>RS FOR MEDICARI</u>	E & MEDICAID SERVICES				OMB NO). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, 1	AULTIP! IILDING	LE CONSTRUCTION	(X3) DATE (
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NAME OF P	ROVIDER OR SUPPLIER		•	143	EET ADDRESS, CITY, STATE, ZIP CODE 33 NORTHGATE ROAD, NW ASHINGTON, DC 20012		
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W 194	review of staff sign had received trainit than 15 months ea facility failed to end competency in improtocol. 2. The facility failed demonstrated com#1's communication a. On August 3, 20 support staff (S2) if Client #1, who was the facility's living a non-verthal, smiled staff. She was obtain, until 8:48 a.m. Later on August 3, home presented a Client #1 as she stroom. However, the time and her coplaced on a table, staff transferred the moments later, a creading to her from another staff trans wheelchair. At 5:3 the back hallway to medications and a to the dining room.	ust 5, 2011. At 11:48 a.m., lature sheets revealed that S2 ng on mealtime protocols more officer (April 16, 2010). The sure that all staff demonstrated elementing Client #1's mealtime of the ensure that staff apetency in implementing Client in training program, as follows: 111, at 6:52 a.m., a direct entroduced this surveyor to a seated in her wheelchair in from. The client, who was widely when introduced by her served in the home from 6:52. 2011, at 4:29 p.m., staff in the communication device to at in her wheelchair in the living here was foud music playing at communication device was At approximately 4:35 p.m., e client to a reclining chair and lirect support staff (S3) began in a book. At 4:57 p.m., S3 and ferred the client back into her 7 p.m., S3 wheeled Client #1 to 0 receive her evening t 5:50 p.m., she was wheeled table for dinner.	W	194			
	on August 4, 2011 Client #1's individu	table for dinner.					

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FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	LTIPLE CONSTRU	ICTION	(X3) DATE S COMPL	
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W 194	(Mercury Voice out persons in her envineeded." The device including pictures of time during the sursupport staff observormunication god Staff in-service trait the facility on Augureview of staff sign training on speech goals and Client #1 been provided on #2010. There was reprovided ongoing sensure that all staff implementing Client b. On August 3, 20 her day program of At 12:15 p.m., she chair. At approximate staff transferred the took her to the ladication 12:24 p.m., a direct her lunch. At 1:13 was full. After gaugexpressions and be "you are full, let's gift out of the lunch." On August 5, 2011, the QMRP revealed would not implement without first having	er communication device put) to communicate with fronment given assistance as ce had 10 pictures on it, or "Eat" and "Drink." At no vey were any of the direct ved implementing the client's all. ning records were reviewed in st 5, 2011. At 11:43 a.m., ature sheets revealed that staff programs, communication 's communication device had farch 30, 2009 and March 25, to evidence that the facility taff in-service training to it #1's communication goal. 11, Client #1 was observed at the facility taff in-service training to it #1's communication goal. 11, Client #1 was observed at the facility taff in-service training to it #1's communication goal. 11, Client #1 was observed at the facility taff in-service training to it #1's communication goal. 11, Client #1 was observed at the facility taff in-service training to it #1's communication goal. 11, Client #1 was observed at the facility taff in the goal feeding p.m., the staff asked her if she ging the client's facial ody language, the staff stated of the client's facial ody language, the staff stated of the client's facial of the client's	W 19	94			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE 8 COMPLI	URVEY
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W 194	program only wants	raining; however, the day ed the speech/ language uct the training and to date,	W 194			
W 249	As soon as the inte formulated a client each client must re treatment program interventions and s and frequency to si	GRAM IMPLEMENTATION rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program	i	W249 The QDDP has scheduled to communication device trained and program staff. The Speech pathologist will ensure that	ning for this I day Language staff are	8/29/11
	Based on observar review, the facility's professional (QMRI received continuous	s not met as evidenced by: tion, staff interview and record qualified mental retardation P) failed to ensure clients is active treatment, for one of the sample. (Client #1)	c T A p w	rained and are able to imple ommunication program of the QDDP will ensure that activities Coordinator at the rogram monitor the staff a reekly to ensure the program plemented correctly.	fectively. she and the e day t least	
	staff (S2) introduce who was seated in living room. The cli smiled widely when	at 6:52 a.m., a direct support of this surveyor to Client #1, her wheelchair in the facility's lient, who was non-verbal, introduced by her staff. She home from 6:52 a.m. until	w m in he	the future the QDDP and ill ensure that all staff are onitored and are capable on the plementing all programs ealth, rehabilitation and saidividuals.	trained and of for the	
,	her day program fro At 12:15 p.m., she	Client #1 was observed at om 12:15 p.m. until 1:23 p.m. was positioned on a beanbag ately 12:17 p.m., day program				

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PRINTED: 08/24/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIÈR/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 09G141 08/05/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW **METRO HOMES** WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION **SUMMARY STATEMENT OF DEFICIENCIES** (X5) COMPLETION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 249 Continued From page 8 W 249 staff transferred the client into her wheelchair and took her to the ladies room to wash her hands. At 12:24 p.m., a direct support staff began feeding her lunch. At 1:13 p.m., the staff asked her if she was full. After gauging the client's facial expressions and body language, the staff stated "you are full, let's go." She then wheeled Client #1 out of the lunch room. Later on August 3, 2011, at 4:29 p.m., staff in the home presented a communication device to Client #1 as she sat in her wheelchair in the living room. However, there was loud music playing at the time and her communication device was placed on a table. At approximately 4:35 p.m., staff transferred the client to a reclining chair and moments later, a direct support staff (S3) began reading to her from a book. At 4:57 p.m., S3 and another staff transferred the client back into her wheelchair. At 5:37 p.m., S3 wheeled Client #1 to ; the back hallway to receive her evening medications and at 5:50 p.m., she was wheeled to the dining room table for dinner. On August 4, 2011, at 10:30 a.m., review of Client #1's individual program plan (IPP) dated December 14, 2010, revealed an objective for Client #1 to "use her communication device

(Mercury Voice output) to communicate with persons in her environment given assistance as needed." The device had 10 pictures on it, including pictures for "Eat" and "Drink." At no time during the survey were any of the direct support staff observed to encourage the client to

use her communication device.

This is a repeat deficiency. See Federal Deficiency Report, dated August 20, 2010.

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		AULTIPLE CONSTRUCTION ILDING	(X3) DATE S	URVEY
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W 257	483.440(f)(1)(iii) PF CHANGE	OGRAM MONITORING &	W	257		
	least by the qualified professional and re- but not limited to sit failing to progress to	ram plan must be reviewed at d mental retardation vised as necessary, including, tuations in which the client is oward identified objectives forts have been made.	·	W257 The individual's tooth brush program has been amended that her oral hygiene is mai staff have been trained in the staff	to ensure intained. All ne new	8/29/11
	Based on observate review, the facility's	s not met as evidenced by: ion, staff interview and record managing staff failed to th brushing program despite Il health. (Client #2)		program. The nursing staff that routine dental cleaning completed at least every 6 recommendations by the de implemented in a timely man	is mths and all entist are	
	approximately 4:00 teeth appeared discreview revealed Clid dated December 14 was assessed as his assessment include teeth #5, #1, #16, # compromised #45." second dental assessment re assessed as having	pust 3, 2011, beginning at p.m., revealed Client #2's colored and uneven. Record ent #2's Dental assessment, I, 2010, revealed this client aving "poor oral hygiene." The ed: "root tip #25, impacted 17, #32, 'periodontally' Client #2 was provided a ssment on March 23, 2011. Evealed Client #2 was provided to severely poor oral hygiene ele decayed and impacted		In the future the QDDP and will ensure that all staff are monitored and are capable implementing all programs health, rehabilitation and saindividuals.	trained and of for the	
:	had a tooth brushing back to December 2	august 5, 2011, at D a.m., revealed the facility g program in place dating 2010. The tooth brushing luled to be implemented for				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU 8. WM	ILDII		TED
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	seven days a weel failed to reflect who minutes of tooth be Despite Client #2's was no evidence produced by substantiate that it assessed or revise 2010. The facility failed to brushing program revised to address her declining oral had 483.470(g)(2) SPA The facility must fur and teach clients to choices about the charing and other dayless interdisciplinary teal. This STANDARD	ach occasion, twice a day and c. The data collection sheets either Client #2 tolerated three rushing as outlined in the plan. It declining oral health, there resented or on file to be tooth brushing program was ad dating back to December to ensure Client #2's tooth was being assessed and her poor oral hygiene despite health. ICE AND EQUIPMENT Thinish, maintain in good repair, to use and to make informed use of dentures, eyeglasses, communications aids, braces,	w:	436		9/1/11
	review, the facility tequipment identifie	iailed to furnish adaptive and as needed by the arm, for one of the three clients]	documentation and weekly updates to DDS regarding the progress of obtaining this WC. All staff were in serviced on the daily	
:	observed seated in room. The front ar	s: , at 6:52 a.m., Client #1 was her wheelchair in the living ad side edges of the foot box were damaged and the right		4	adaptive equipment monitoring form. See attached in service record and WC – paperwork sent to vendor.	

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FORM APPROVED

	•	I AND HUMAN SERVICES 8 MEDICAID SERVICES					APPROVED 0.0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION LOING		(X3) DATE S COMPL	
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NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 1433 NORTHGATE ROAD, N WASHINGTON, DC 2001:	W		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFU TAG		ACTION SHOUTO THE APPRI	ILD BE	(X5) COMPLETION DATE
	along a 5-inch long towards the left and her back. [Note: Rediagnosis of scolios positioned in a specific positioned in which the control provided "insufficient pressur "uncomfortable" for "new custom molde wheelchair. A PT a 7, 2010, indicated sinew wheelchair on the control professional (QMRI received a new seas vendor had gone or been delays in getting the QMRP present primary care physic requesting "new custom review and the client recent efforts made seating. [Also see \ 483.470(i)(2)(i) EVA	and tom in numerous areas swath. Her body was angled if there was a notable curve to accord review later revealed a sis.] The client's head was cial pillow. at 3:38 p.m., review of Client by (PT) records revealed a sy Assessment, dated October the PT wrote that the seating ded wheelchair was "in "insufficient support" and re relief" and was the client. He recommended at seating only" for her existing assessment dated December the had been "molded for her October 15, 2010." at approximately 9:40 a.m., uslified mental retardation P) revealed Client #1 had not ting system. She said the first at of business and there had a 719A form, signed by the ian on September 22, 2010, stom molded wheelchair." 719A form available for the secure the custom molded W159] ACUATION DRILLS	W 4				
		tually evacuate clients during the year on each shift.					

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		HAND HUMAN SERVICES E & MEDICAID SERVICES						APPROVED 0. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	_	(X3) DATE S	SURVEY
		09G141	B. WI	NG.			08/	05/2011
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZII 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHO THE APPR	ULD BE	COMPLETION DATE
W 445	Continued From pa	age 12	W	44!	5			
	Based on staff into facility failed to ensigning the past cer residents' health ar	is not met as evidenced by: erview and record review, the ure at least one full evacuation tification year to ensure the nd safety, for six of the six he facility. (Clients #1, #2, #3,		Al Sa M sa	7445 Il staff were in serviced of afety and Evacuation by larshall. A new evacuation fety plan has been introcaff were in serviced on i	the Fire on and duced a	e fire	8/19/11
	The finding include	s:		e.	ee attached in service rec	oord on	d	
W 446	retardation profess house manager (Happroximately 2:00 had any full evacuaback from the date August 4, 2011, at failed to provide an evacuation had occarditional interview HM confirmed that occurred nor was than any had taken place 483.470(i)(2)(ii) EV	acility's qualified mental ional (QMRP) and the facility's M) on August 4, 2011, at p.m., revealed they have not ations over the past year dating of survey. Record review on approximately 2:15 p.m., also y evidence that a full curred over the past year. I with both the QMRP and the no full evacuation had here any written evidence that e over the past year. ACUATION DRILLS	w 4	ev	vacuation plan	And all	u	
		ake special provisions for the is with physical disabilities.						
	Based on observar review, the facility f provisions to ensur wheelchairs for mo facility safely in the	s not met as evidenced by: tion, staff interview and record ailed to establish special e all clients who required bility were able to exit the event of an emergency e of the six clients residing in						

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		AND HUMAN SERVICES				FORM	UB/Z4/ZU11 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
_		09G141	B. WING			08/05/2011			
NAME OF P	PROVIDER OR SUPPLIER		s		ADDRESS, CITY, STATE, ZIP CODE NORTHGATE ROAD, NW				
METRO	HOMES		WASHINGTON, DC 20012						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
W 446	Continued From pa	ge 13	W 44	6					
	approximately 9:30 four major points or door, rear door, bathe facility's qualified professional (QMR manager (HM) on approximately 2:05 and #6 always used during evacuation of and the HM, that we for those clients be with an access rample the HM indicated the facilitating any other was in QMRP indicated the would handle the sear exit was in QMRP indicated the would handle the sear exit was in QMRP indicated the would handle the sear exit was in QMRP indicated the would handle the sear exit was in QMRP indicated the would handle the sear exit was in QMRP indicated the would handle the sear exit was in QMRP indicated the would handle the sear exit was in QMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with the GMRP indicated the would handle the search with t	facility of August 3, 2011, at a.m., revealed the facility had f egress (front door, kitchen sement door). Interview with admental retardation P) and the facility's house August 4, 2011, at p.m., revealed Clients #1, #4 d the "rear door" of the facility drills. According to the QMRP as the only egress they used cause it was the only egress up. In addition, the QMRP and hey had never thought of ar means for Clients #1, #4 and y during fire drills. When ures would be implemented if accessible, the HM and the ey were not sure how they ituation.	i	Safe Mars safet staff See a	staff were in serviced on Fir ty and Evacuation by the Fi shall. A new evacuation and y plan has been introduced were in serviced on it. attached in service record and uation plan	ire d fire and all	8/19/11		

Health K	egulation & Licensin	o Administration					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT A. BUILDIN B. WING	PLE CONSTRUCTION	(X3) DATE S COMPLE 08/0	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	PRESS, CITY,	STATE, ZIP CODE		
METRO H	IOMES			THGATE R TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
1 000	INITIAL COMMENT	тѕ		I 000			
	2011 through Augu		e of three				
	observations and in residents in the hor	survey were based on terviews with staff at the and at one day properties of the resident and administ ancident reports.	nd rogram, as				
1 090	3504.1 HOUSEKES	EPING		1 090			
	maintained in a safe and sanitary manner	terior of each GHMR e, clean, orderly, attr er and be free of irt, rubbish, and obje	active,	1	 The chairs legs have be tightened. 2. All the debris and libeen cleaned out. 		9/1/11
	Based on observati Home for Persons (GHPID) maintaine the facility in a safe sanitary manner, er observations, for si	met as evidenced by ion and interview, the with Intellectual Disa of the interior and extended to the interior and extended to the interior and extended to the six residents #1, #2, #3, #4, #5 are:	e Group ibilities terior of active, and g of the	e T c e c u R	all staff were in serviced of nvironmental safety and so the QDDP,RC and QA Montinue to complete montinuity nvironmental audits and so the continue to report safety has an itary practices to the C on a daily basis.	sanitation. Janager will Staff will Exards and Jacob Pand	
		, beginning at 12:32 ction of the facility re			ee attached in service rection for the control of t		
	1. The legs of one or room table were wo	of the six chairs at thobbly.	e dining				; ; ; ;
ealth Regula ABORATORY		DER/SUPPLIER REPRESED	WITATIME'S SIGN		J28811	ICVS If continued	(X6) DATE

STATE FORM

Health F	legulation & Licensir	ng Administration					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILD	ING	X3) DATE SU COMPLE	
		HFD03-0104		B. WING		08/0	5/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		
METRO	HOMES			RTHGATE I	ROAD, NW 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE	(X5) COMPLETE DATE
∤ 090	Continued From pa	ge 1	i	1090		į	
	debris observed in day of survey. The	nificant amount of litte the front driveway on trash remained in th it the three-day surve	the first				
I 180	3508.1 ADMINISTE	RATIVE SUPPORT		l 180	I180		8/31/11
	needs of the reside Habilitation plans. This Statute is not Based on observati	provide adequate ort to efficiently mee nts as required by the met as evidenced by on, staff interview an tome for Persons wit	eir : d record		1. The staff involved has been disciplined and re trained in this individual's mealtime protocol. QDDP and the RC/RN will ensurthey monitor the staff during mealtimes at least 2x/week, to enthat the mealtime protocol is being	The re that	
	adequate administrative residents' needs	ies (GHPID) failed to ative staff to effective s, for six of the six re nts #1, #2, #3, #4, #5	ely meet sidents of		followed. 2. The QDDP has scheduled the communication device training for		
	The findings include	3 :			individual's residential and day program staff. The Speech/Langu	uage	
	to ensure that all sta #1 with her meals in training, to ensure it	29.1) The qualified es professional (QID aff assigned to assist the home received emplementation of the Protocol, as written.	Resident effective	1	pathologist will ensure that staff a trained and are able to implement communication program effective The QDDP will ensure that she a Activities Coordinator at the day	are t the ely. nd the	
	failed to ensure that Resident #1's day p training to ensure in resident's Mercury \	29.2. and I422] The staff in the home an rogram received effe optementation of the voice output communed training program.	d at ctive	•	program monitor the staff at least weekly to ensure the program is b implemented correctly.		
	3. The QIDP failed t implementation of the equipment policies,	ne facility's adaptive					

Health F	requiation a Licensin	ig Administration				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT A. BUILDIN B. WING _		(X3) DATE SURVEY COMPLETED 08/05/2011
NAME OF F	DOMEST OF PLOTHES	10.000-010-1	STREET AD	DEES OF	STATE, ZIP CODE	00/03/2011
NAME OF P	PROVIDER OR SUPPLIER					
METRO	HOMES			RTHGATE R STON, DC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	NULD BE COMPLETE
1 180	Continued From pa	ige 2		l 180		
	Cross-refer to 1500 seating system was #1's physical therap physician in Octobe the resident was with a. When interviewe approximately 9:40 she had sought the wheelchair vendors Resident #1's PT reof efforts to secure since October 15, 20. Resident #1's Individated December 14 indicated that her with made no reference Assessment, dated the PT wrote that the disrepair," provided "insufficient pressur" uncomfortable for c. On August 5, 201	a.1. A new custom most recommended by Repist (PT) and primary et 2010. As of August thout the new seating at on August 5, 2011, a.m., the QIDP indices services of three differ. However, review of seconds failed to show the custom molded seconds. 11, at 10:02 a.m., revidual Support Plan (IS 4, 2010, revealed that wheelchair was "function to the Seating and NI October 15, 2010, in the seating system "will "insufficient support re relief" and was	Resident care st 5, 2011, g system. , at cated that ferent if revidence seating view of SP), at it itoning." It Mobility n which cas in " and	w ar ap H D en ex do D ob Al ad	The paperwork to request a reheelchair has been sent to the ad will be forwarded to Delma proval. The QDDP and Metromes will work closely with the DS adaptive equipment reput asure that a new WC is obtained to peditiously. There will be cure cumentation and weekly upder DS regarding the progress of the staff were in serviced on the aptive equipment monitoring the attached in service record a paperwork sent to vendor.	Vendor arva for he co ed crent ates to daily form.
	March 18, 2011, an QIDP wrote Reside reported to meet he report made referer Assessment, dated included the aforem recommendation fo seating system.	ed again on June 17, ent #1's "seating systement #1's "seating systemeds at this time." Ince to the Seating and October 15, 2010, the entioned problems are a new custom mole	2011, the em is em is em is em is em is em is em			
	stated that direct su equipment checklist	11, at 11:56 a.m., the upport staff used an a t to document daily n esidents' adaptive eq	edaptive nonitoring			! : :

Health F	Regulation & Licensin	ng Administration			•	10111	ATTROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A. BUILDIN B. WING _	IPLE CONSTRUCTION	(X3) DATE S COMPLI	ETED
NAME OF F	POMPED OR CURRING	HF003-0704	STREET AD	DDESS CITY	STATE, ZIP CODE	00/0	5/2011
NAME OF F	PROVIDER OR SUPPLIER						
METRO	HOMES			RTHGATE RESTON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
l 180	Continued From pa	ige 3		I 180			
	#1's program book 2010 - August 5, 20 routinely reported ther seating system 3, 2011, however, the wheelchair was obsided the was no evidence the accuracy of the state		october aff leeded for leed August leer d. There fied the	pr th st pr th co re	The individual's tooth brust rogram has been amended to that her oral hygiene is maintained from the rogram. The nursing staff with at routine dental cleaning is completed at least every 6 mthe commendations by the dental commendations are considered at least every 6 mthe commendations are commendations.	ensure ained. All new ll ensure hs and all ist are	
	Policies and Proces approximately 2:15 QMRP has the prin facilitating the timel replacement of equipment shall octrom when the need (replacement) do the QIDP shall progovernment agency and monitoring of a Moments later, inter that she had not not Coordinator, to inclistrategies to obtain agency's policies as	•	011, at The , or , repair, the date f 0 days," the cements . confirmed ce delay and ne	in W m in he in 5. Sa M sa: sta Se ev	the future the QDDP and R ill ensure that all staff are transition and are capable of applementing all programs for ealth, rehabilitation and safet dividuals. All staff were in serviced on a fety and Evacuation by the larshall. A new evacuation as fety plan has been introduce aff were in serviced on it. The attached in service record accuation plan.	ner. C/RN Ained and The Ty of the Fire Ind fire Id and all The Ty and and	
	a resident's tooth b resident's poor oral 5. [Cross-refer to F- Citation W445] The one full evacuation	(23) The QIDP failed rushing program des health. ederal Deficiency Re QIDP failed to ensure during the past certificalth and safety of its control of the past certificalth and safety of its certificalth and safety of	pite the port - re at least ication	Sa Ma sai sta Se	All staff were in serviced on fety and Evacuation by the I arshall. A new evacuation ar fety plan has been introduced ff were in serviced on it. e attached in service record accuation plan	Fire nd fire d and all	

6. [Cross-refer to Federal Deficiency Report -

J28811

Health F	Regulation & Licensin	ng Administration					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		HFD03-0104		D. VVING		08/0	5/2011
NAME OF P	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
METRO	HOMES			RTHGATE ROSTON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
1 180	Continued From pa	ige 4		l 180	·		
	special provisions to required wheelchair the facility safely in	e QIDP failed to estable to ensure all residents its for mobility were all the event of an emere of the six residents.	s who ble to exit rgency				
I 229	3510.5(f) STAFF T	RAINING	j	1229			:
	Each training progn limited to, the follow	ram shall include, but ving:	not be		9 c QDDP has scheduled the numinication device training	for this	8/29/11
	residents to be sento, behavior manag	related to the GHMRI ved including, but not jement, sexuality, nut mmunications, and as	t limited trition,	indi stafi will able	ividual's residential and day f. The Speech/Language pat ensure that staff are trained to implement the communi	program hologist and are cation	
	Based on observati verification, the faci demonstrated comp residents' individual	met as evidenced by ions, interviews and rility failed to ensure sipetency in implement of program plans, for che sample. (Residen	record staff ting one of the	progensus Coo	gram effectively. The QDDP are that she and the Activitie rdinator at the day program staff at least weekly to ensurgram is being implemented comments.	will es monitor the control of the c	
	demonstrated comp	I to ensure that staff petency in implement		ensu mon	ne future the QDDP and RC/ are that all staff are trained as itored and are capable of	nd	:
	a. Resident #1, who feed her due to sev hands, was observe home on August 3, The meal consisted boiled egg and cold pureed consistency feeding her alternat	time protocol, as folk to was dependent on a vere contractures of b ed being fed breakfast 2011, beginning at 8 d of an English muffin d cereal, all prepared v. The direct support a ted between the food ce drink throughout the	staff to both st in her 3:25 a.m. n, hard at a staff (S2)	rehal	ementing all programs for the bilitation and safety of the in	ne health, ndividuals.	

nealui r	requiation & Licensir	ig Administration					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0104		(X2) MULTIP A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE S COMPLI	
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
METRO	HOMES			THGATE ROTON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL.	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
	August 3, 2011. Be fed her lunch which peas, mashed pota breakfast observati offer the resident at p.m., the day prograthe resident water a supplement 30 min lunch, as per the re (MP). Review of the 2010, revealed the minutes after break after lunch: 1 c fluid b. On August 5, 20 observed feeding R 7:54 a.m., after the her food, S2 gave the nutritional supplement Review of the same 2010, revealed that given as a "mid-mobreakfast. On both mornings, Resident #1's MP, and Staff in-service train the facility on August review of staff signs.	pserved at her day preginning at 12:24 p.m. consisted of pureed toes and apple saucions, day program stany fluids while she at am staff said she wo and a Boost Plus nutrutes after she finishe sident's Mealtime Pre MP, dated December of the MP, dated Decembers of the mealth of the Boost Plus was a ming snack," not with S2 failed to implement swritten. S2 failed to implement syritten.	n., staff meat, e. Unlike aff did not e. At 1:03 uld give ritional d her otocol per 5, "30 0 minutes vas rifast. At 1 eating is ip. er 5, to be n her riewed in a.m., I that S2 cols more	1229			
:	facility failed to ensu competency in implementatime protocol. 2. The facility failed	ure that all staff demo ementing Resident#	onstrated 1's				

J28811

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A BUILDING B. WING HFD03-0104 08/05/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1433 NORTHGATE ROAD, NW **METRO HOMES WASHINGTON, DC 20012** PROVIDER'S PLAN OF CORRECTION **SUMMARY STATEMENT OF DEFICIENCIES** (XS) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 1229 Continued From page 6 1229 Resident #1's communication training program, as follows: a. On August 3, 2011, at 6:52 a.m., a direct support staff (S2) introduced this surveyor to Resident #1, who was seated in her wheelchair in the facility's living room. The resident, who was non-verbal, smiled widely when introduced by her staff. She was observed in the home from 6:52 a.m. until 8:48 a.m. Later on August 3, 2011, at 4:29 p.m., staff in the home presented a communication device to Resident #1 as she sat in her wheelchair in the living room. However, there was loud music playing at the time and her communication device was placed on a table. At approximately 4:35 p.m., staff transferred the resident to a reclining chair and moments later, a direct support staff (S3) began reading to her from a book. At 4:57 p.m., S3 and another staff transferred the resident back into her wheelchair. At 5:37 p.m., S3 wheeled Resident #1 to the back hallway to receive her evening medications and at 5:50 p.m., she was wheeled to the dining room table for dinner. On August 4, 2011, at 10:30 a.m., review of Resident #1's individual program plan (IPP) dated December 14, 2010, revealed an objective for Resident #1 to "use her communication device (Mercury Voice output) to communicate with persons in her environment given assistance as needed." The device had 10 pictures on it, including pictures for "Eat" and "Drink." At no time during the survey were any of the direct support staff observed implementing the resident's communication goal. Staff in-service training records were reviewed in

Health R	tegulation & Licensin	ng Administration					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		HFD03-0104				08/0	5/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
METRO I	HOMES			THGATE RESTON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETE DATE
1229	the facility on Augus review of staff signs training on speech goals and Resident had been provided 25, 2010. There we provided ongoing sensure that all staff implementing Resident beautiful to the control of the con	st 5, 2011. At 11:43 ature sheets revealed programs, communication on March 30, 2009 as no evidence that the taff in-service training demonstrated compident #1's communication 11, Resident #1 was from 12:15 p.m. until she was positioned approximately 12:17 ferred the resident in the tage of the tunch. At 1:13 pine was full. After galoressions and body to une full, let's go." Still out of the lunch ro	d that staff cation device and March the facility g to betency in ation goal. observed if 1:23 on a p.m., day atto her com to the support o.m., the aging the anguage, the then	1 229			
	the QMRP revealed program would not goal without first ha on its use. The QM offered to provide to program only wants	at 1:15 p.m., intervient that Resident #1's of implement her commoving their staff receivable further indicated raining; however, the ed the speech/languet the training and to occurred.	day nunication ve training i that she day age				
l 422	3521.3 HABILITAT	ION AND TRAINING	i i	1 422			
:	and assistance to re	l provide habilitation, esidents in accordan vidual Habilitation Pt	ce with				•
	This Statute is not	met as evidenced by	r				

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i icalii ix	egulation & Licensin	g Administration					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE S COMPLE	ETED
·		HFD03-0104				08/0	5/2011
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIP CODE		
METRO H	IOMES			THGATE R TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE APPROPRIED TO THE	OULD BE	(X5) COMPLETE DATE
1 422	Continued From pa	ge 8		1 422			
	verification, the facinesidents' training of accordance with the (ISP), for one of the sample. (Resident: The findings include On August 3, 2011, staff (S2) introduced who was seated in I living room. The resmited widely when was observed in the 8:48 a.m. On August 3, 2011, her day program from the side of the same	,	sure that mented in Plan te support sident #1, facility's -verbal, aff. She n. until	T c iii p p tr c c c T A	A22 The QDDP has scheduled the ommunication device training adividual's residential and da rogram staff. The Speech/Lar athologist will ensure that star ained and are able to implement ommunication program effect the QDDP will ensure that she activities Coordinator at the deceive to ensure the program monitor the staff at lease the program in the pr	y nguage iff are ent the tively. e and the ay ast	8/29/11
	chair. At approxima staff transferred the and took her to the hands. At 12:24 p.r began feeding her li asked her if she waresident's facial expthe staff stated "you wheeled Resident # Later on August 3, 2 home presented a conception of the time asked her if as she living room. However playing at the time asked was placed on a tabp.m., staff transferrectair and moments (S3) began reading	ntely 12:17 p.m., day resident into her wholadies room to wash m., a direct support sunch. At 1:13 p.m., it is full. After gauging ressions and body later full, let's go." Single 1 out of the lunch rown at in her wheelchaiter, there was loud mand her communication devices at in her wheelchaiter, a direct support to her from a book.	program eelchair her taff the staff the inguage, he then om. taff in the e to r in the usic on device / 4:35 eclining rt staff At 4:57	w m in he	the future the QDDP and Ro ill ensure that all staff are tra- onitored and are capable of aplementing all programs for ealth, rehabilitation and safety dividuals.	ined and the	

Health R	egulation & Licensin	g Administration					
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		HFD03-0104		B. WING_	<u></u>	08/0	5/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
METRO	10MES			THGATE RESTON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PRÉFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
l 422	Continued From pa	ge 9		1 422			
	S3 wheeled Reside receive her evening	ner wheelchair. At 5: ent #1 to the back hal g medications and at eled to the dining roo	lway to 5:50				
	Resident #1's individed by the comber 14, 2010 Resident #1 to "use (Mercury Voice outpersons in her environmental medical." The device including pictures for time during the sun	at 10:30 a.m., reviewed an object the communication put) to communicate ronment given assisted and 10 pictures on or "Eat" and "Drink." I wey were any of the dived to encourage the ication device.	PP) dated ive for device with ance as it, At no lirect				
		iciency. See Federa dated August 20, 20 ⁻					; ·
I 42 3	3521.4 HABILITATI	ION AND TRAINING	,	1 423			:
	resident's Individu ongoing basis to en resident and approp of such Plans when	I monitor and review al Habilitation Plan o isure participation of oriate GHMRP staff i never necessary. The Il be documented wit	n an the n revision e schedule				:
	Based on observati review, the facility's revise a resident's t	met as evidenced by on, staff interview an managing staff faile booth brushing progra i's poor oral health. (d record d to im				

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nealli) r	<u>(egulation & Licensir</u>	ig Administration					
	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER HFD03-0104			A BUILDING B. WING			URVEY ETED 5/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY.	STATE, ZIP CODE		
METRO			1433 NOR	THGATE R	OAD, NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
1 423	Continued From pa			1 423			:
	The finding include	S:			1		•
	approximately 4:00 teeth appeared discreview revealed Re assessment, dated this resident was as hygiene." The asse #25, impacted teeth 'periodontally' comp was provided a sec March 23, 2011. The Resident #2 was as poor oral hygiene a and impacted teeth Record review on A approximately 10:0 had a tooth brushin back to December program was sched three minutes on easeven days a week failed to reflect whe three minutes of toplan. Despite Resident was no evider substantiate that the assessed or revised 2010. The facility failed to brushing program was scheduled to reflect was no evider substantiate that the assessed or revised 2010.	December 14, 2010 ssessed as having "pessment included: "ron #5, #1, #16, #17, #5 comised #45." Resident dental assessment revealed assessment revealed assessment required extractional assessment required extractional assessment required extractional assessment revealed that required extractional assessment revealed the grogram in place of 2010. The tooth brustilled to be implemented to be implemented as a collection of the Resident #2 token the properties of the properties o	dent #2's Record , revealed poor oral pot tip 32, dent #2 ent on aled everely decayed tion." facility lating shing ated for a day and a sheets erated ned in the ral health, file to gram was ember	T p th st p th co re in M m in h	the individual's tooth brushing rogram has been amended to enat her oral hygiene is maintain taff have been trained in the norogram. The nursing staff will nat routine dental cleaning is completed at least every 6 mthe ecommendations by the dentise in the future the QDDP and Royall ensure that all staff are train nonitored and are capable of implementing all programs for ealth, rehabilitation and safety andividuals.	ensure ned. All ew lensure s and all t are er. C/RN ned and	8/29/11
I 500	3523.1 RESIDENT			I 500			
	Each GHMRP resid	lence director shall e	nsure				

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Health R	egulation & Licensi	no Administration				- 	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE S COMPL	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE		-
METRO I				THGATE RETON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
I 500	Continued From p	age 11		1 500			
	protected in accor-	esidents are observed dance with D.C. Law in applicable District and	2-137, this	Ti w	00 ne paperwork to request a new heelchair has been sent to the control of the co	ne Vendor	9/1/11
	Based on observareview, the Group Intellectual Disabil and protect reside Title 7, Chapter 13 called D.C. Law 2-Chapter 19) and fit Sub-Part 1 (for Intellectual Persons with Mentiture residents in The findings included 1. [483.470(g)(2)]	t met as evidenced by tions, interviews and Home for Persons wi ities (GHPID) failed to the D.C. Code (for 137, D.C. Code, Title ederal regulations 42 ermediate Care Facilital Retardation), for on the sample. (Resider de: The GHPID failed to ommended adaptive examples and the commended adaptive examples.	record th o observe nce with rmerly 6, CFR 483 ties for ne of the nt #1)	ar H D er de D ol A	and will be forwarded to Delay oproval. The QDDP and Me omes will work closely with DS adaptive equipment represent that a new WC is obtained and weekly us DS regarding the progress obtaining this WC. All staff were in serviced on daptive equipment monitorice attached in service recompaperwork sent to vendor.	tro th the to ined current pdates to of the daily ng form.	
	On August 3, 2011 was observed sea living room. The f box on her wheeld right arm rest was areas along a 5-in angled towards the curve to her back, revealed a diagnohead was position. On August 3, 2011 Resident #1's phyrevealed a Seating dated October 15,	1, at 6:52 a.m., Residented in her wheelchair ront and side edges of their were damaged a worn and torn in nunch long swath. Her be left and there was a [Note: Record reviews of scoliosis.] The ed in a special pillow. 1, at 3:38 p.m., reviews ical therapy (PT) record and Mobility Assess 2010, in which the Parker custom molded.	in the of the foot and the nerous ody was notable w later resident's v of ords ment, T wrote				

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Health R	equiation & Licensin	a Administration					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTII A. BUILDING B. WING	PLE CONSTRUCTION 3	(X3) DATE S COMPL	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADO	DRESS, CITY, S	STATE, ZIP CODE		
METRO I	10MES			THGATE ROTON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
1 500	Continued From pa	ge 12	1	I 500			:
	and "insufficient pro" "uncomfortable" for recommended "new for her existing who dated December 7, "molded for her new 2010." On August 5, 2011 interview with the quantitative with the quantitative professional (QIDP not received a new first vendor had go had been delays in then. The QIDP proby the primary care 2010, requesting "received and the professional than the promary care available for review not reflect any received."	v custom molded sea elchair. A PT asses 2010, indicated she w wheelchair on Octo , at approximately 9:4 ualified intellectual di) revealed Resident is seating system. She ne out of business ar getting another vence esented a 719A form physician on Septer	s ating only" sment had been ober 15, 40 a.m., isabilities #1 had e said the hd there dor since h, signed mber 22, form ecord did ocure the				
		mprehensive evaluat on plan [Formerly § 6					
	purposes of this ch receive habilitation,	of funds appropriated apter, each custome, care, or both consisons included in the cu on plan.	r shall tent with				
:	interview and recor to ensure that Resi the use of her com- accordance with re	P) Based on observated verification, the factorial dent #1 received trainmunication device, in commendations in help (ISP), in the horeast.	ility failed ning on I er		-		

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METRO HOMES STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012 [X4] ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) R 000 INITIAL COMMENTS A licensure survey was conducted from August 3, 2011 through August 5, 2011. A sample of three residents was selected from a population of six women with profound intellectual and developmental disabilities. The findings of the survey were based on observations and interviews with staff and residents in the home and at one day program, as well as a review of resident and administrative records, including incident reports. R 125 4701.5 BACKGROUND CHECK REQUIREMENT R 125	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDI B. WING	4.4.	(X3) DATE COMP	
(A) ID SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL PREFIX (EACH DEFICIENCY) R 000 INITIAL COMMENTS A licensure survey was conducted from August 3, 2011 through August 5, 2011. A sample of three residents was selected from a population of six women with profound intellectual and developmental disabilities. The findings of the survey were based on observations and interviews with staff and residents in the home and at one day program, as well as a review of resident and administrative records, including incident reports. R 125 4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all juriadictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by. Based on interview and review of personnel records, the group home for persons with intellectual disabilities (GHPID) failed to ensure criminal background checks for all juriadictions in which the employees had worked or resided within the 7 years prior to the check, for 1 out of 14 direct support staff. (S1) The finding includes: On August 3, 2011, at approximately 3:00 p.m., review of the personnel record for S1 revealed that a Maryland background check had been documented on March 12, 2008. However, her	NAME OF PROVIDER OR SUPPLIE		STREET ADD	RESS, CITY,	STATE, ZIP CODE		
R 000 INITIAL COMMENTS A licensure survey was conducted from August 3, 2011 through August 5, 2011. A sample of three residents was selected from a population of six women with profound intellectual and developmental disabilities. The findings of the survey were based on observations and interviews with staff and residents was selected from and administrative records, including incident reports. R 125 4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker for the previous seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and review of personnel records, the group home for persons with intellectual disabilities (GHPID) failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for 1 out of 14 direct support staff. (S1) The finding includes: On August 3, 2011, at approximately 3:00 p.m., review of the personnel record for S1 revealed that a Manyland background checks thad been documented on March 12, 2008. However, her	METRO HOMES						
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review of the personnel record for S1 revealed that a Maryland background check had been documented on March 12, 2008. However, her	A licensure surve 2011 through Au residents was se women with prof developmental d. The findings of the observations and residents in the level as a review records, including the criminal history of contract worker from all jurisdictions employee or contract worker from the check. This Statute is in Based on intervience ords, the ground intellectual disaborism all backgrowhich the employeem of the finding including the finding including the contract supports the ground the finding including the contract supports the cont	ey was conducted from gust 5, 2011. A sample lected from a population ound intellectual and isabilities. The survey were based of interviews with staff at nome and at one day proof resident and administig incident reports. COUND CHECK REQUING INTERVIEWS WITH A PROVINGE COUND CHECK REQUING THE prospective employers the previous seven (a) within which the prospectate worker has worked a seven (7) years prior to the check for all jurisor yees had worked or resistant. (S1)	e of three on of six on of six on of six on on of six on of six on of sirative or	R 125	The background check for completed. Metro Homes process of developing a discreminder system which will avert these critical own the future, the QA dependentinue to complete a quadit.	s is in the lata base and in the future versights. artment will parterly HR	8/31/11
Falls Church, VA from 2005 - 2007 as well as in	review of the per that a Maryland to documented on the resume indicated Falls Church, VA	sonnel record for S1 re packground check had March 12, 2008. Howe I that she had been em from 2005 - 2007 as w	been been ver, her ployed in				:

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